Medication dispensed at incorrect dose
(04HDC10307, 1 March 2005)

Pharmacist ~ Dispensing error ~ Dosage ~ Checking ~ Standard operating procedures ~ Systems review ~ Professional standards ~ Right 4(2)

An ophthalmologist prescribed a 42-year-old woman a short-term course of prednisone to prevent the development of cystoid macular oedema (inflammation of the retina).

He prescribed 30mg of prednisone to be taken on a daily basis for the first two weeks, followed by a reduced dosage of 20mg daily for the next two weeks. Prednisone comes in 1mg, 5mg and 20mg doses. Although the correct number of tablets was dispensed, the pharmacist mistakenly selected the 20mg tablets instead of the 5mg tablets.

The woman suffered severe side effects from ingesting four times the intended dose. As the ophthalmologist had warned the woman that there might be side effects, at first she did not give too much thought to them. After five days, however, she contacted the ophthalmologist as she thought the reactions were more severe than had been indicated.

The ophthalmologist was surprised that the woman's reactions were so adverse to what was a relatively low dosage. However, over the next few months the dosage was altered to take into account the woman's apparent sensitivity. A further script was filled for 1mg prednisone. The woman alternated her dose, but what was meant to be alternations between 5mg and 4mg was in fact between 20mg and 4mg. Erratic reactions to the medication continued.

The dispensing error was discovered only when the woman compared her medication to the prednisone prescribed to her mother.

The pharmacy had stored both the 5mg and the 20mg tablets on a cabinet shelf in white containers that were essentially the same except for a purple band and an orange band, respectively. Although the different dosages come in different colours, this distinction is not obvious when the tablets are put into brown-tinted glass bottles.

As a result of the error, the pharmacist introduced an additional checking measure. He now leaves the container from which a prescription is dispensed on the counter until the prescription is collected, rather than return it to the shelf upon filling the script. The container is then checked against the script.

It was held that although the pharmacist had documented standard operating procedures that had been recently audited, his practice did not meet professional standards, as evidenced by his failure to pick up his error with checking procedures. This amounted to a breach of Right 4(2).